

State of Utah
**FLEXIBLE REIMBURSEMENT
ACCOUNT PROGRAM (FLEX \$)
SALARY REDUCTION AGREEMENT**

PLAN YEAR _____

SECTION A - EMPLOYEE INFORMATION

Name (First, Middle, Last)		EIN	Work Phone	
Agency/Dept	Division		Low Org.	
Home Address		City	State	Zip

SECTION B - SALARY REDUCTION INFORMATION

	Biweekly	Plan Year (biweekly amount x 26)
		Amounts may be adjusted for rounding
Qualified Health Care Account	\$ _____	x 26 = \$ _____
(Medical, dental, or vision out of pocket expenses for you, your spouse, or dependent children.) Minimum \$10.00 per pay period; maximum \$5,000 per plan year.		
Qualified Dependent Care Account	\$ _____	x 26 = \$ _____
Day care expenses only for your dependent children.) Minimum \$10.00 per pay period, maximum \$5,000 per plan year (\$2,500 if married and planning to file a separate IRS tax return.		
Total Salary Reduction	\$ _____	x 26 = \$ _____

SECTION C - DEPENDENT INFORMATION

List all dependents to be covered for Section 125 Health Care and/or Dependent Care Accounts for the Plan Year.

Name (First, Middle, Last)	Social Security Number	Date of Birth	Relationship	Using Dependent Care?
				Yes No
Name (First, Middle, Last)	Social Security Number	Date of Birth	Relationship	Using Dependent Care? Yes No
Name (First, Middle, Last)	Social Security Number	Date of Birth	Relationship	Using Dependent Care? Yes No
Name (First, Middle, Last)	Social Security Number	Date of Birth	Relationship	Using Dependent Care? Yes No
Name (First, Middle, Last)	Social Security Number	Date of Birth	Relationship	Using Dependent Care? Yes No
Name (First, Middle, Last)	Social Security Number	Date of Birth	Relationship	Using Dependent Care? Yes No
Name (First, Middle, Last)	Social Security Number	Date of Birth	Relationship	Using Dependent Care? Yes No

Use reverse side for additional dependents, and check here. []

SECTION D - ELECTION AUTHORIZATION AND ACKNOWLEDGMENT

I hereby, authorize my employer to reduce my gross salary in the amounts designated above and contribute them to the designated FLEX\$ account(s). I further acknowledge that the State shall reimburse approved expenses from the qualified appropriate account(s) up to the maximum annual amount elected. I agree to pay the amount designated per pay period to cover this annual listed total. In the event the State pays or has paid an amount exceeding that which has been contributed by me, I promise and agree to repay the State for all amounts paid in excess of that which I have contributed.

I acknowledge and understand that the wage reduction amount(s) will not exceed my gross wages for that same period. Further, I Understand that any biweekly reduction amount so designated herein will be reflected on the pay period statement following the effective date of participation in the Plan. Should such a reduction fail to be made, I will correct such failure by contacting the plan administrators no later than the next pay period. Failure to take such corrective action will cancel my participation for the remainder of the current Plan Year. I also acknowledge and understand that the deduction reflected herein is irrevocable, except as otherwise provided for in such respective Plan booklet which I have received and read. Any amounts in my accounts not properly claimed or used by me shall be forfeited to the State. I certify that the dependents listed above are eligible dependents according to Section 152(a) of the IRS Code.

Employee's Signature	Date
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SECTION E - PLAN ADMINISTRATOR USE ONLY

Date Approved and Processed	Approved By
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